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Testimony of the American Psychiatric Association

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House Veterans Affairs Subcommittee on Health

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Mr. Chairman and members of the Subcommittee, I am Joseph T. English, M.D., the Chairman of St. Vincent's Catholic Medical Centers of New York City and Professor and Chairman of Psychiatry at New Medical College. New Medical College is affiliated with two VA hospital centers: Montrose and Castle Point. I thank you for the opportunity to present the American Psychiatric Association's (APA) recommendations for appropriations for the Department of Veterans Affairs (VA) health care and medical research programs for fiscal year (FY) 2008. The APA consists of over 37,000 psychiatric physicians nationwide who specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders.

First, I would like to thank the members of the Subcommittee and your House colleagues for your commitment to providing the highest quality medical care for our nation's veterans and for supporting necessary research to advance the quality of that care.

The APA is grateful for the $786 million the President requested for Outpatient Mental Health Care, Readjustment Counseling and VA Mental Health Initiative.[1] Sadly, it may not be adequate to meet the growing needs of veterans with mental illnesses.

Current and Emerging Needs of OEF/OIF Vets

VA and the Department of Defense (DOD) are well aware that a significant percentage of combat veterans of Operations Enduring and Iraqi Freedom (OEF/OIF) are at risk for PTSD and other mental health problems. In a 2006 study published in the Journal of the American Medical Association, Col. Charles Hoge, MD, of the Walter Reed Military Research Institute, evaluated relationships between combat deployment and mental healthcare use in the first year following return from the war.

The Hoge study found that 19 percent of soldiers and Marines who had returned from Iraq screened positive for mental health problems including PTSD, generalized anxiety, and depression. Col. Hoge reported that mental health problems recorded on the postdeployment self-assessments by military service members were significantly associated with combat experiences and mental health-care referral and utilization. Thirty-five percent of Iraq war veterans had received mental health services in the year after returning home, and 12 percent each year were diagnosed with a mental problem. According to study findings, mental health problems remained elevated at 12 months postdeployment among soldiers preparing to return to Iraq for a second deployment. Col. Hoge postulated that although OIF veterans are using mental health services at a high rate, many military personnel with mental health concerns do not seek help due to fear of stigma and other barriers. The study revealed that service members resisted care because of personal concerns over being perceived as weak—or that seeking treatment would have a negative impact on their military career. Finally, Col. Hoge noted that the high use rate of mental health services among veterans who served in Iraq following deployment illustrates the challenges in ensuring that there are adequate resources to meet the mental health needs of this group, both within the military services themselves and in follow-on VA programs.

[1] Combination of: Outpatient Mental Health Care $311m, Readjustment Counseling $115m and Mental Health Initiative $360m from the President Fiscal Year 2008 Budget Proposal

The VA health-care system is also seeing increasing trends of health-care utilization among OEF/OIF veterans. VA reports that veterans of these current wars seek care for a wide range of possible medical and psychological conditions, including mental health conditions such as adjustment disorder, anxiety, depression, PTSD, and the effects of substance abuse. As of November 2006, VA reported that of the 205,000 separated OEF/OIF veterans who have sought VA health care since fiscal year 2002, a total of 73,157 unique patients have received a diagnosis of a possible mental health disorder. Nearly 34,000 of the enrolled OEF/OIF veterans had a probable diagnosis of PTSD.2

VA has intensified its outreach efforts to OEF/OIF veterans and reports that the relatively high rates of health-care utilization among this group reflect the fact that these veterans have ready access to VA health care, which is free of charge for two years following separation from service for problems related to their wartime service. However, VA estimates that only 109,191 veterans of the Iraq and Afghanistan wars will be seen in VA facilities in 2007 (1,375 fewer than expected to see in 2006). With increased outreach, internal mental health screening efforts under way, and expanded access to health care for OEF/OIF veterans, we are concerned that these estimates are artificially low and could result in a shortfall in funding necessary to meet the demand.

VA's PTSD Programs

According to VA, it operates a network of more than 190 specialized PTSD outpatient treatment programs throughout the country, including specialized PTSD clinical teams or a PTSD specialist at each VA medical center. Vet centers, which provide readjustment counseling in 207 community-based centers, have reported rapidly increasing enrollment in their programs, with nearly 77,000 readjustment counseling visits of OEF/OIF veterans in fiscal year 2005 and projected visits of 242,000 in fiscal year 2006.

Because of increased roles of women in the military and their exposure to combat in OEF/OIF theaters, we encourage VA to continue to address, through its treatment programs and research initiatives, the unique needs of women veterans related to treatment of PTSD and military sexual trauma. Although VA has improved access to mental health services at its 800-plus community-based outpatient clinics, such services are still not readily available at all sites. Likewise, VA has not yet achieved its goal of integration of mental health staff in all its primary care clinics. Also, we remain concerned about the capacity of specialized PTSD programs and the decline in availability of VA substance-use disorder programs of all kinds over time, including virtual elimination of inpatient detoxification and residential treatment beds. Although additional funding has been dedicated to improving capacity in some programs, VA mental health providers continue to express concerns about inadequate resources to support, and consequently rationed access to, these specialized services.

[2] Independent Budget, Critical Issues Report on Fiscal Year 2008

Mental Health and Traumatic Brain Injury

Traumatic brain injury (TBI)—caused by IEDs, vehicular accidents, gunshot or shell fragment wounds, falls, and other traumatic injuries to the brain and upper spinal cord—is the signature injury of Operations Enduring and Iraqi Freedom. Severe TBI resulting from blast injuries or powerful bomb detonations that severely shake or compress the brain within the skull often causes devastating and permanent damage to brain tissue. Likewise, veterans who are in the vicinity of an IED blast or involved in a motor vehicle accident can suffer from a milder form of TBI that is not always immediately detected and can produce symptoms that mimic PTSD or other mental health disorders. Research from Charles Marmar, M.D., at the San Francisco VA Clinic indicates that many OEF/OIF veterans have suffered mild brain injuries or concussions that have gone undiagnosed and that injury symptoms will only be detected later when these veterans return home.

We are concerned about emerging literature3 that strongly suggests that even "mild" TBI patients may have longterm mental and medical health consequences. The DOD admits that it lacks a systemwide approach for proper identification, management, and surveillance for individuals who sustain mild to moderate TBI/concussion, in particular mild TBI/concussion. Therefore, the VA should coordinate with the DOD to better address mild TBI/concussion injuries and develop a standardized follow-up protocol utilizing appropriate clinical assessment techniques to recognize neurological and behavioral consequences of TBI as recommended by the Armed Forces Epidemiological Board.

The VA has designated TBI as one of its special emphasis programs and is committed to working with the DOD to provide comprehensive acute and long-term rehabilitative care for veterans with brain injuries. We are encouraged that VA has responded to the growing demand for specialized TBI care and, fulfilling the requirements of Public Law 108-422, established four polytrauma rehabilitation centers (PRCs) that are collocated with the existing TBI lead centers. However, we remain concerned about capacity and whether VA has fully addressed the resources and staff necessary to provide intensive rehabilitation services, treat the longterm emotional and behavioral problems that are often associated with TBI, and support families and caregivers of these seriously brain injured veterans.

Long-Term Mental Health Services for Veterans

Over the past fifteen years, there has been an increase in the number of veterans with serious mental illnesses being treated by the VA. This is partially attributable to other avenues of care becoming closed (e.g., when private insurance coverage for mental illness becomes exhausted or Medicaid systems are stretched to the breaking point). Over 90% of the veterans being treated for psychosis are so ill that they cannot maintain a significant income and therefore become indigent and heavily reliant on the VA for their care.

Until recently, mental health care has not been a priority for VA. Virtually every entity with oversight of VA mental healthcare programs – including Congressional oversight committees,

[3] August 11, 2006, memorandum, issued by the Armed Forces Epidemiological Board regarding Traumatic Brain Injury in Military Service Members

the GAO, VA's Committee on Care of Veterans with Serious Mental Illness, and The Independent Budget – have documented both the extensive closures of specialized inpatient mental health programs and VA's failure in many locations to replace those services with accessible community-based programs. The resultant dearth of specialized inpatient care capacity and the failure of many networks to establish or provide appropriate specialized programs effectively deny many veterans access to needed care. These gaps highlight VA's ongoing problems in meeting statutory requirements to maintain a benchmark capacity to provide needed care and rehabilitation through distinct specialized treatment programs and a comprehensive array of services.

Congress has directed the VA to substantially expand the number and scope of specialized mental health and substance abuse programs to improve veterans' access to needed specialized care and services (P.L. 107-135). The law details the VA's obligation to make systemic changes network-by-network to reverse the erosion of that specialized capacity. Congress has made clear that the criteria by which the "maintain capacity" obligation is to be met are hard, measurable indicators that are to be followed by all Veterans Integrated Service Networks (VISNs).

Substance Abuse Treatment

Veterans with substance use disorders are drastically underserved. It has been the experience of some of my colleagues in the VA that returning soldiers with PTSD often try to mask their anxiety and panic symptoms by using alcohol or drugs such as marijuana. The APA is concerned that veterans who may be waiting for specialized substance abuse care may in fact have co-occurring PTSD that has not been adequately identified, or that vets are forced onto a wait list for a substance abuse treatment bed. A delay in treatment can have serious consequences. The dramatic decline in VA substance use treatment beds has reduced physicians' ability to provide veterans a full continuum of care, often needed for those with chronic, severe problems. Funding for programs targeted to homeless veterans who have mental illnesses or co-occurring substance use problems does not now meet the demand for care in that population. Additionally, despite the needs of an aging veteran population, relatively few VA facilities have specialized geropsychiatric programs.

Military Families

The APA remains deeply concerned about the ancillary mental health care available from TRICARE to family members of a soldier who is deployed. The same holds true for the families of veterans who have returned and are experiencing readjustment problems. The VA currently only has an informal network of support groups to help families develop the coping and support skills necessary when a loved one is experiencing PTSD. The TRICARE services available are largely dictated by a family's geographic accessibility to a military base. The APA would like to encourage the DoD and VA to continue to work together for a seamless transition of soldier family to veterans family and that family resilience be an important factor in the comprehensive care of veterans.

Care for Homeless Veterans

The APA applauds the inclusion of funds in the Administration's budget to enhance and expand services for homeless veterans through the Samaritan Initiative, which is co-administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Housing and Urban Development (HUD). Psychiatric and substance abuse disorders contribute significantly to homelessness among veterans. Studies show that about one-third, or approximately 250,000 homeless individuals have served their country in the armed services. Over 40% of homeless veterans suffer from persistent and disabling mental illnesses, and 69% have substance abuse disorders. The VA's healthcare system is a safety net and, within that context, providing treatment and support services for homeless veterans is one of the VA's important missions.

MIRECCs and Research

The APA wishes to compliment the VA for initiating the Mental Illnesses Research, Education and Clinical Centers (MIRECCs). The MIRECCs serve as infrastructure supports for psychiatric research into the most severe mental illnesses. Additionally, the APA would like to compliment the VA Research Office for initiating the Quality Enhancement Research Initiative (QUERI), which has funded two new field centers focused on putting into clinical application evidence-based treatment for schizophrenia, depressive disorders, and substance use disorders. However, the nominal increase in the President's research budget request is likely to limit the implementation of this farsighted plan.

The APA supports the Independent Budget's request for $480 million for VA Medical and Prosthetic Research (an increase of $69 million over the President's request; with an additional $45 million for research facility improvements. Despite high productivity and success, funding for VA medical and prosthetic research has not kept pace with other federal research programs or with funding for VA medical care. The VA research program has done an extraordinary job leveraging its modest $412 million FY06 appropriation into a $1.7 billion research enterprise that hosts multiple Nobel laureates and produces an exceedingly competitive number of scientific papers annually. VA Research awards are currently capped at $125,000, significantly lower than comparable federal research programs. However, VA investigators would be unable to compete for additional funding from other federal sources without the initial awards from the Medical and Prosthetic Research account.

Psychiatric research funding originates with the VA's medical and prosthetics budget. Regrettably, it is inadequate to support the full costs of the VA research portfolio and fails to provide the resources needed to maintain, upgrade and replace aging facilities. VA medical and prosthetics research is a national asset that helps to attract high-caliber clinicians to practice medicine and conduct research in VA health care facilities. The resulting environment of medical excellence and ingenuity, developed in conjunction with collaborating medical schools, benefits every veteran receiving care at VA, and ultimately benefits all Americans. VA research is patient-oriented: over 60% of VA researchers treat veterans. As a result, the Veterans Health Administration, the largest integrated medical care system in the world, has the unparalleled ability to translate progress in medical science to improvements in clinical care.

Fellowships, Psychiatric Education and Workforce Issues

Closely related to research efforts are the training needs of professional staff members. The VA should provide sufficient funding to the Office of Academic Affiliations for furthering fellowships in the field of severe mental illness (SMI) patient care and other areas. Fellowships should also emphasize the multidisciplinary needs of effective mental health care, addressing the elements of a recovery- and quality of life-based care system, as well as evidence-based best practices in psychosocial rehabilitation.

The APA applauds the VA for initiating the program for Psychiatric Primary Care Education (PsyPCE), which allows psychiatric residents to assume the duties of primary care physicians for mentally ill patients in mental health and primary care settings. We regard this as an opportunity to enhance the capabilities of psychiatric trainees to provide psychiatric care at primary care settings in order to reach a sector of veterans with psychiatric illness who normally would not have come to the attention of mental health professionals. It is, however, important for VA to maintain its core psychiatric residency and fellowship training capabilities. Rapid expansion of psychiatric knowledge and the challenges of providing quality care to veterans at different venues would require the availability of additional competent psychiatric physicians.

The shortage of physicians and other mental health professionals has compromised the services VA provides and has endangered patient safety. Many veterans with mental illnesses are medically fragile – with diabetes, liver or kidney failure, or cardiac disease, for example. Their care requires a specially trained physician. A revision of salary schedules, recognition of the contributions of International Medical Graduates and minority American Medical Graduates, and the availability of Continuing Medical Education (CME) courses and other professional opportunities for advancement need to be addressed. We understand that there is a significant shortage of nursing staff -- especially psychiatric nurses -- and we request that the VA address this shortage area.

Summary

Overall, the APA is pleased with the direction VA has taken and the progress it has made with respect to its mental health programs. We are also pleased that the DOD has acknowledged that it needs to conduct more rigorous pre- and post-deployment health assessments and reassessments with military service personnel who serve in combat theaters and that it is working to improve collaboration with VA to ensure this information is accessible to VA clinicians. Likewise, VA and the DOD are to be commended for attempting to deal with the issue of stigma and the barriers that prevent service members and veterans from seeking mental health services. Although we recognize and acknowledge both agencies' efforts, the DOD and VA are still far from achieving the universal goal of "seamless transition."

Emerging evidence suggests that the burden of combat-related mental illness from OEF/OIF will be high. Utilization rates for health care and mental health services predict an increasing demand for such services in the future, and evidence suggests that the current wars are presenting new challenges to the DOD and VA health-care systems. Fortunately, Americans are united in agreeing that care for those who have been wounded as a result of military

service is a continuing cost of national defense. PTSD, TBI, and other injuries with mental health consequences that are not so easily recognizable can lead to serious health catastrophes, including occupational and social disruption, personal distress, and even suicide if not treated.

Recommendations

The APA is deeply concerned about veterans with mental illness and substance abuse disorders. We believe it is important to secure:

- additional and specifically allocated funding for mental health and substance abuse services;
- immediate nationwide implementation of clinical programs mandated within the system;
- enforcement of compliance with legislation aimed at maintaining capacity; and
- enhanced recruitment and retention of personnel who will improve the care and lives of veterans with mental illnesses and substance abuse disorders.

The APA is concerned that VA mental health service delivery has not kept pace with advances in the field. State-of-the-art care requires an array of services that include intensive case management, access to substance abuse treatment, peer support and psychosocial rehabilitation, pharmacologic treatment, housing, employment services, independent living and social skills training, and psychological support to help veterans recover from a mental illness. The VA's Committee on Care of Veterans with Serious Mental Illness has recognized that this continuum should be available throughout the VA. However, at most, it can be said that some VA facilities have the capability to provide some limited number of these services to a portion of those who need them. The APA recommends that Congress incrementally augment funding for mental illness and substance use disorders by $500 million each year from FY08 to FY12 above FY06 levels.

Above all, a profound respect for the dignity of patients with mental and substance use disorders and their families must be duly reflected in serving the needs of veterans in the VA system. I appreciate the opportunity to speak with you today on behalf of the American Psychiatric Association.